CITY OF SCOTTSDALE
FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT FORM

Please type or print.

EMPLOYEE INFORMATION

NAME: _____ SOCIAL SECURITY NUMBER: _____

MAILING ADDRESS: _____
Street Unit No. City State Zip Code

☐ Check this box if address has changed since last claim was filed

HOME PHONE: (____) _____ WORK PHONE: (____) _____

HEALTH CARE REIMBURSEMENT

To ensure the prompt processing of your reimbursement request, please be sure to attach copies of your Explanation of Benefits statement prepared by your insurance carrier, receipts and/or any additional documentation to support each of the reimbursement requests listed below.

	Date of Service	Provider of Service	Amount of Reimbursement
1			
2			
3			
4			
5			
6			
		TOTAL REIMBURSEMENT REQUEST	

DEPENDENT CARE REIMBURSEMENT

Dependent Name/Relationship	Age	Dates of Service	Amount
		TOTAL REIMBURSEMENT REQUEST	

NAME OF DEPENDENT CARE PROVIDER: _____ SOCIAL SECURITY/ TAX ID NUMBER: _____

ADDRESS: _____
Street Unit No. City State Zip Code

SIGNATURE OF PROVIDER: _____ DATE: _____
(Not required if signed and itemized receipt is attached)

EMPLOYEE SIGNATURE

I hereby request payment from my Flexible Spending Account for the expenses itemized above. I certify that I have not requested reimbursement under this plan or from any other source for these expenses. I also certify that the total dependent care expenses (if any) for which I am requesting reimbursement this plan year do not exceed the lesser of my or my spouse's earned income for the year. I further certify that the expenses I am submitting for payment are eligible expenses, as explained in my open enrollment material and in I.R.S. publications 502 and 503. I understand that expenses paid through these accounts cannot be claimed on my personal income tax return.

EMPLOYEE SIGNATURE: _____ DATE: _____

Submit completed form and documentation to: Human Resources 7575 E. Main Street Scottsdale, AZ 85251